INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

TARGETED CASE MANAGEMENT FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

OPERATIONS MANUAL

Effective October 1, 2001

Revised February 2002

1.0 INTRODUCTION

The State of Indiana has received approval from the Centers for Medicare and Medicaid Services (CMS) for an amendment to its State Medicaid Plan to add Targeted Case Management for Individuals with Developmental Disabilities. The amendment is in accordance with Section 1915 (g) (1) of the Social Security Act. Targeted Case Management for Individuals with Developmental Disabilities has two components – Intake Case Management and Ongoing Case Management.

1.1 TARGET GROUP

The target group consists of persons who are eligible for developmental disabilities services under Indiana Code 12-7-2-61(2). Developmental disability means a severe chronic disability of a person which (A) is attributable to a mental or physical impairment or combination of mental and physical impairments (other than the sole diagnosis of a mental illness); (B) is manifested before the person attains the age of twenty-two; (C) is likely to continue indefinitely; (D) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated; and (E) results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care; (ii) receptive and expressive language; (iii) learning; (iv) mobility; (v) self-direction; (vi) capacity for independent living; (vii) economic self-sufficiency.

1.2 DEFINITIONS OF SERVICES

Case management for individuals with developmental disabilities is a specialized form of case management. To receive case management services, the individuals must meet eligibility requirements established by the State. Case management services enable an individual with developmental disabilities to receive a full range of appropriate services in a planned, coordinated, efficient and effective manner to promote the well being of the individual. Targeted Case Management consists of two components: Intake Case Management and Ongoing Case Management. Together these two components include the responsibility for locating, managing, coordinating, and monitoring: a) all proposed services; b) needed medical, social, educational and other publicly funded services, regardless of funding source; and c) informal community supports needed by eligible persons.

1.3 PROVIDER TYPES

The Indiana Division of Disability, Aging, and Rehabilitative Services (DDARS) Bureau of Developmental Disabilities Services (BDDS) district offices and the local Area Agencies on Aging (AAA) offices will provide the intake component of targeted case management. Ongoing case management providers will be entities that undertake to provide such services, and meet and comply with standards set by DDARS. Entities that

are approved by BDDS to provide services to persons with developmental disabilities and/or their employees may be certified to provide on-going case management, if the entity and specific employee meets the TCM requirements. (See Section 10.0.)

2.0 TARGETED CASE MANAGEMENT COMPONENTS

2.0A INTAKE CASE MANAGEMENT

Intake Targeted Case Management includes assisting the individual through the application process, authorizing any needed assessments to determine eligibility, collecting current diagnostic information, determining eligibility, assisting the individual in choosing an Ongoing Targeted Case Manager, and effecting a smooth transition to the Ongoing Targeted Case Manager.

2.0B ONGOING CASE MANAGEMENT

Ongoing Targeted Case Management includes service planning, advocating for the individual, linking the individual with available community services, monitoring the individual's satisfaction, as well as monitoring all services delivered to the individual that are designed to assist individuals with developmental disabilities. The Ongoing Case Manager may determine initial level of care for purposes of determining eligibility for Medicaid waiver services. The Ongoing Case Managers will assist the individual with the person centered planning process and update assessments and eligibility periodically.

2.1 ELIGIBILITY TO RECEIVE TARGETED CASE MANAGEMENT

Because Targeted Case Management for Individuals with Developmental Disabilities is a regular Medicaid service, it is an entitlement that is available to all individuals who are eligible.

An individual is eligible to receive Intake Targeted Case Management if he/she is being evaluated for Medicaid-funded services for persons with developmental disabilities. Medicaid will fund Intake Targeted Case Management activities for Medicaid recipients. Medicaid Waiver administrative reimbursement will fund Intake Targeted Case Management activities for individuals who are determined to be ineligible for Medicaid.

Individuals who meet State eligibility requirements for having a developmental disability and are Medicaid eligible can receive Ongoing Case Management.

Targeted Case Management for Individuals with Developmental Disabilities cannot duplicate other Medicaid-funded services with case management components. Individuals who are enrolled in a Medicaid managed care program (for example, Hoosier

Healthwise) may need assistance in clarifying their eligibility status.

It is not necessary for an individual to meet level of care criteria for an Intermediate Facility for the Mentally Retarded (ICF/MR), nor for an individual to be on a Medicaid Home and Community-Based Services (HCBS) Waiver Program in order to be eligible for Targeted Case Management services.

Individuals who receive services under the Medicaid HCBS Waiver Program for Individuals with Developmental Disabilities, however, must receive all of their case management through Targeted Case Management for Individuals with Developmental Disabilities because case management is not included as a Waiver service. In addition, individuals on a Waiver waiting list, individuals receiving services through State funds, and other individuals can receive this specialized case management service if they are eligible.

Individuals who are not on a Medicaid HCBS Waiver Program may elect not to receive Targeted Case Management for Individuals with Developmental Disabilities.

If an individual receives Case Management services under a Medicaid 1915 (c) Home and Community-Based Services Waiver that includes Case Management services (for example, the Aged and Disabled, Medically Fragile Children, Traumatic Brain Injury and Assisted Living Medicaid Waivers), he/she is not eligible for Targeted Case Management for Individuals with Developmental Disabilities.

2.2 APPLICATION PROCESS TO RECEIVE SERVICES

Individuals interested in applying for Targeted Case Management services or for other services for individuals with developmental disabilities should contact one of the local BDDS district offices or a local AAA office. The Intake Targeted Case Manager at either of these offices will take an application, talk with the individual and his/her family about service options, collect existing collateral information, authorize any needed assessments, and determine eligibility.

Once an individual is determined to be eligible, the Intake Case Manager will provide information regarding all approved Ongoing Case Managers. The individual has freedom to choose any qualified Ongoing Case Manager. The Intake Case Manager then works with the individual's chosen Ongoing Case Manager to transition all necessary information.

3.0 TARGETED CASE MANAGEMENT ACTIVITIES

3.0A INTAKE CASE MANAGEMENT

Initial Referrals and Applications - receiving referrals from individuals who need services, assisting individuals through the application process, disseminating information regarding programs and services, and providing coordination to resources.

Collection of Current Diagnostic Collateral – collecting documentation and information needed for final determination of eligibility for developmental disabilities services.

Authorizing Assessments –identifying and authorizing assessments needed for eligibility determinations and to plan services for individuals with developmental disabilities in the least restrictive setting possible.

Eligibility Determination – determining initial eligibility for level of care and other non-Medicaid eligibility requirements established by the State. For all individuals, the BDDS must determine whether that individual is eligible for State-funded services for persons with developmental disabilities. If an individual is eligible for State-funded services and also wishes to apply for the Medicaid Waiver Program, then a Qualified Mental Retardation Professional (QMRP) of the BDDS, the AAA, or the Indiana Office of Medicaid Policy and Planning (OMPP) must determine for all individuals whether that individual is eligible for services requiring ICF/MR level of care.

Communication With Ongoing Case Manager – coordinating a smooth, seamless exchange of information with the Ongoing Case Manager chosen by the individual.

3.0B ONGOING CASE MANAGEMENT

Communication With Intake Case Manager – coordinating a smooth, seamless exchange of information with the Intake Case Manager.

Eligibility Determination – determining and periodically redetermining eligibility for level of care and other non-Medicaid eligibility requirements established by the State. A QMRP employed by BDDS, AAA, OMPP, or an approved Targeted Case Management entity determines eligibility for community services requiring ICF/MR level of care (Medicaid waiver services). BDDS determines whether an individual continues to meet the state's definition of developmentally disabled.

Person Centered Planning Process – assisting the individual to participate in the process of person centered planning in order to discover the strengths and needs of the individual.

Service Planning - developing a long term and short term plan of services, based upon the needs and interests of the individual, and developing the financial support plan that is needed to support the services requested.

Linkages to Community Services – continuing the support of the individual's current needs with paid and unpaid community services, coordinating the selection of service providers to work directly with the individual, coordinating the transition plans with the selected provider and the individual, and assisting individuals to locate safe and appropriate housing.

Advocacy for the Individual – advocating for the consumer with providers and in the community.

Monitor Service Delivery and Utilization – monitoring to ensure quality of care by case reviews which focus on the individual's progress in meeting goals and objectives established through the service plan. Oversight of providers to assure services delivered are timely and of high quality and that service utilization is in line with authorized service amounts.

Oversight and Initiation of the Annual Assessment Process – identifying needs and interests and gathering other information needed to continue services for individuals with developmental disabilities in the least restrictive setting possible.

Coordination of Crisis Services – implementing procedures for quick response to consumers in crisis, including coordinating necessary actions, authorizing short-term services, and involving providers or other entities as needed to resolve the crisis. Responsibilities include close monitoring until the situation is resolved.

ICF/MR and Nursing Facility Transition Services – coordinating the transition of individuals with developmental disabilities from ICF/MR or nursing facility settings to community settings, following established procedures. Transition services would not duplicate discharge planning done by the facility. An individual may receive targeted case management services for up to six months prior to discharge from the facility.

Liaison Activities – maintaining professional communication between the consumer/guardian, service providers and the appropriate state agencies.

Incident Report Completion, Submission, and Follow-Up – completing and submitting incident reports to the State and following up on incident reports until difficulty resolved.

Monitor Consumer Satisfaction and Service Outcomes - monitoring and soliciting, at least annually, the satisfaction of the individuals receiving services. Utilizing a satisfaction tool approved by the State**.** Monitoring outcomes of service delivery.

Maintain Records – maintaining appropriate records, including database, per specifications of the State.

4.0 FREE CHOICE OF PROVIDERS

Targeted case management services for individuals with developmental disabilities will not restrict the individual's free choice of providers of other Medicaid services, nor will targeted case management be used to restrict access to other Medicaid services available under the Medicaid State Plan.

Individuals of the target population may choose from any of the qualified case managers who deliver services in the individuals' district of residence.

Providers serving an individual on the DD or Autism Waivers may not provide Targeted Case Management to that individual. Also, the same provider cannot provide both services and Targeted Case Management to an individual served 24-hours by the Individual Community Living Budget (ICLB). If an individual moves on to one of these services and has a provider of other services providing case management, that provider will have to choose either services or TCM. Exceptions to this policy are at the discretion of the Director of the Integrated Field Service Offices. In addition, an individual/employee providing other DD services to an individual, may not provide case management to that individual.

5.0 DUPLICATION OF SERVICES

Payment for targeted case management services for individuals with developmental disabilities under the Plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

6.0 UTILIZATION OF TARGETED CASE MANAGEMENT

Utilization of Targeted Case Management shall be based on the needs of the individual; however, Ongoing Case Management for each individual is limited to no more than an average of 10 hours/month. If more case management service is required for a particular individual, the Ongoing Case Manager shall contact the local BDDS district office for written authorization to exceed that limit. Each BDDS district office shall have an individual who is responsible for responding to these requests.

BDDS approval should be in advance of service being provided. For an individual in crisis, the Case Manager is to provide case management services as needed to protect the individual's health and safety and must submit a request for BDDS approval within 3 calendar days following the onset of the crisis.

The Ongoing Case Manager should realize that increased utilization of case management or any other service could affect the cost-effectiveness for an individual on a HCBS Waiver.

7.0 INTAKE CASE MANAGEMENT PROCESSES

7.1 APPLICATION

The Intake Case Manager will complete the intake application form. When the individual applies with an AAA office an Application for Long-Term Care Services form is to be completed. When the individual applies with a BDDS office, the BDDS application for services form and an Application for Long-Term Care Services form are to be completed.

At that time, the Case Manager should also obtain signed Release of Information forms to use in acquiring copies of historical information, diagnostic testing and other relevant collateral material to be used in determining if the individual meets the State definition for having a developmental disability.

During the application process, the Case Manager is to ascertain if the individual is a current Medicaid recipient. If the individual has not applied for Medicaid, the Case Manager shall explain that the Medicaid application process is through the local county office of the Division of Family and Children (DFC). The individual and his/her family must understand the importance of applying for Medicaid. The Case Manager will assist the individual through the Medicaid application process, as necessary, and will work in coordination with the caseworker at the county DFC office.

7.2 ENTERING DATA INTO DATABASE

All pertinent information obtained through the application process shall be entered into the database utilized by DDARS within 3 calendar days. For individuals applying for Medicaid HCBS Waivers, the Data Entry Worksheet shall be entered to facilitate tracking of the individual, as well as automatically referring the individual for other possible services with either BDDS or the AAAs.

7.3 GATHERING COLLATERAL INFORMATION

Within 3 calendar days, the Intake Case Manager shall send written requests (with an attached, signed Release of Information form) to all possible sources of collateral information, including schools, to obtain sufficient documentation to determine eligibility. As part of this process, the individual's family physician shall be sent the Medicaid Form 450B to complete and return to the Case Manager.

The Case Manager should follow up on each request by phone within 15 days of mailing the request. If the needed information has not arrived by 30 days after the request was mailed, and there is insufficient information to determine eligibility, the Case Manager shall order needed diagnostic testing and/or evaluations.

The Case Manager shall also follow up on the individual's Medicaid eligibility determination, as necessary, with the local county DFC office.

7.4 COMPLETING THE DEVELOPMENTAL DISABILITIES PROFILE

The Intake Case Manager will complete a Developmental Disabilities Profile (DDP) for each individual as an early part of the Intake process. The DDP assesses an individual's functioning, as well as highlights the needs of that individual. The DDP results will assist the Case Manager to determine if the individual is eligible for services for individuals with developmental disabilities and if the individual meets the ICF/MR level of care. (See Attachment A for the Developmental Disabilities Profile form.)

7.5 ORDERING DIAGNOSTIC TESTING AND EVALUATIONS

The Intake Case Manager will order only those specific diagnostic tests or evaluations that are necessary to complete the determination of State eligibility for services for individuals with developmental disabilities. For example, collateral information may be available to document the individual's functioning, but no valid IQ score is available. In that instance, the Case Manager would order psychological testing. For another individual, an IQ score may be valid and there may be some data regarding functioning, but not enough information regarding certain functional areas. In such a situation, the Case Manager might order a specific functional evaluation.

A "complete" package of psychological testing, case analysis, and functional assessments should never be requested unless absolutely necessary to determine eligibility.

7.6 DETERMINING STATE ELIGIBILITY FOR SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Only BDDS can make this eligibility determination. An Intake Case Manager who works for an AAA must submit the needed information to the local BDDS district office for a determination. A BDDS Service Coordinator will make the determination within 5 calendar days. If additional information is needed before a determination is possible, the Service Coordinator will contact the AAA Intake Case Manager to explain what is still required.

7.7 DETERMINING ICF/MR LEVEL OF CARE

When an individual has applied for a Medicaid Waiver and has been determined by BDDS to meet the State eligibility to receive services for individuals with developmental disabilities, the Intake Case Manager will review all relevant information in order to reach an ICF/MR level of care determination.

"Routine" level of care determinations may be completed by the Intake Case Manager or by a QMRP for the BDDS or AAA office when the Intake Case Manager is not a QMRP. (Please see Section 10.0 for the qualifications for certification as a QMRP.)

"Non-routine" level of care evaluations must be submitted to OMPP for determination by its QMRP staff for individuals under the following circumstances:

1. An IQ of 65 or above;
2. Dual diagnosis with IQ 55 or above;
3. Significant medical conditions requiring specialized medical supports or that significantly interfere with participation in services;
4. Requires two or more staff on-site for any part of the day for more than 30 days;
5. Under age 18; or
6. Police involvement due to maladaptive behaviors.

In completing a "routine" level of care evaluation, the QMRP must review psychological, social, medical and additional records necessary to have a current and valid reflection of the individual. These records may be older than one year if the QMRP certifies that they continue to be a valid reflection of the individual. If collateral records are not available or are not a valid reflection of the individual, additional assessments may be obtained through the local BDDS-contracted diagnostic and evaluation (D&E) team. The level of care packet must also include:

1. A completed Medicaid Form 450B medical form (sections 1, 2, 3, and 6) signed and dated by a physician within the past year; and
2. A DDP completed by a Targeted Case Manager within the past year.

A "non-routine" level of care packet must be completed and submitted to the OMPP and include:

1. Transmittal for Medicaid Level of Care Eligibility (HCBS form 7) completed by the Case Manager and assuring that the information is a current and valid reflection of the individual;
2. A completed Medicaid Form 450B medical form (sections 1, 2, 3, and 6) signed and dated by a physician within the past year;
3. A DDP completed by a Targeted Case Manager within the past year;
4. Psychological, social and medical information as needed to assist the OMPP QMRP in the determination of level of care. The information may be older than one year if the Case Manager certifies that it is a valid reflection of the individual.

The OMPP QMRP may request additional information, including an updated D&E, from the Case Manager to assist in the determination of level of care.

Once level of care is approved, the Intake Case Manager shall assure that the approval is entered into the appropriate database (DART or INsite). If the individual has applied for a Medicaid Waiver, the date the individual signed the Application for Long-Term Care Services form is to be used as the effective date for the appropriate Waiver waiting list.

OMPP will routinely pull a random sample of the level of care determinations made by all Targeted Case Managers to review for accuracy.

If the level of care decision results in a denial, the individual may appeal that decision. The Case Manager shall send written notification to the individual explaining the decision and the appeals process. If the individual has applied for a Medicaid Waiver,

the Case Manager is to enter the level of care denial information into the database to remove the individual from the Waiver waiting list.

7.8 TRANSFERRING CASE TO ONGOING CASE MANAGER

For the individual who is Medicaid eligible and meets the State eligibility to receive services for individuals with developmental disabilities, but does not meet level of care, the Intake Care Manager will offer the individual a choice of approved Ongoing Case Managers serving the area. The individual is free to choose any of the qualified Case Managers on the Ongoing Case Manager list. Different lists will be provided based on services an individual is receiving. Individuals receiving services through the DD or Autism Waivers or 24-hour supports through State Line Item, will receive a list containing only AAA and Independent Case Mangers. Although this individual will not be eligible for Medicaid HCBS Waiver services, the individual can still receive Ongoing Case Management, as well as other services that his/her Case Manager can arrange.

For the individual who is Medicaid eligible, meets the State eligibility to receive services for individuals with developmental disabilities, and meets level of care, the Intake Care Manager will offer the individual a choice of approved Ongoing Case Managers serving the area. The individual who also meets ICF/MR level of care shall remain on the waiting list for the appropriate Medicaid HCBS Waiver Program, utilizing the date of his/her original application.

Once the individual has chosen an Ongoing Case Manager, the individual shall sign a statement noting the choice made.

The Intake Case Manager will work in collaboration with the chosen Ongoing Case Manager to make a smooth transition. While the Intake Case Manager must retain records to document the Intake Case Management activities, diagnostic testing, and other information, the Intake Case Manager must provide the chosen Ongoing Case Manager with copies of the DDP, all diagnostic testing and evaluations and other relevant information.

8.0 ONGOING CASE MANAGEMENT PROCESSES

8.1 RECEIVING A CASE FROM INTAKE CASE MANAGER

The Ongoing Case Manager will coordinate a smooth exchange of information with the Intake Case Manager. All records shall be thoroughly reviewed, and the Ongoing Case Manager shall contact the individual, the individual's family, and others invited by the individual to set up the first meeting of these individuals who will serve as the support team.

8.2 PERSON CENTERED PLANNING PROCESS

The Ongoing Case Manager is responsible for assuring the Person Centered Planning (PCP) process occurs. The initial meeting to begin the PCP process should take place no more than 30 days after the Ongoing Case Manager receives the case. Often the Case Manager serves as the facilitator, but the individual always has the right to choose another member of his/her support team to facilitate PCP meetings. The Ongoing Case Manager should be familiar with the PCP process and will assist the team to discover the strengths and needs of the individual

The Ongoing Case Manager shall be trained in and follow the DDARS-approved Person Centered Planning Process. (See Attachment B for Person-Centered Planning Guidelines.)

8.3 SERVICE PLANNING FOR INDIVIDUALS NOT ON A HCBS WAIVER

The Ongoing Case Manager shall develop a long-term and short-term plan of services, based upon the needs and interests of the individual. These shall be spelled out in detail in the Individual Support Plan (ISP) for that individual. (See Attachment C for the Guidelines for the Completion of the Individualized Support Plan and the Individualized Support Plan form.)

For individuals who receive services funded through a Medicaid HCBS Waiver, State Line Item dollars or other BDDS funding, the ISP should be submitted to the local BDDS District office for review and approval when the individual's budget is submitted (see section 8.5). Each BDDS district office shall have a contact person for non-Waiver ISPs and one for Waiver ISPs.

8.4 IDENTIFYING AND CHOOSING PROVIDERS

Part of the service planning process involves locating resources to deliver services and supports that the individual needs. The Case Manager shall be knowledgeable about community services and non-Waiver funding sources that may be available to the individual and assist the individual through any application process specific to those sources. In addition, the Case Manager should utilize natural supports, volunteers and unpaid services whenever possible.

When an individual is to receive services funded by BDDS and/or a Medicaid Waiver, the Ongoing Case Manager will share with the individual and his/her support team a list of all certified providers of the services needed by the individual in the county(ies) chosen by the individual. The individual has the right to choose the service provider from all the available providers. The Ongoing Case Manager will contact the chosen providers and arrange for service delivery.

In addition, the Ongoing Case Manager will work in collaboration with other entities, including but not limited to the school system, Vocational Rehabilitation, public housing service, and healthcare providers to assist the individual with obtaining services to meet the needs of the individual.

8.5 FUNDING SERVICES AND COMPLETING THE "ICLB"

For individuals who will be receiving services funded through BDDS funding streams, an Individual Community Living Budget form (ICLB) is required. The Ongoing Case Manager will work with the chosen service providers to complete the first ICLB. When completed, the ICLB will be submitted to the local BDDS district office for review and approval. Services cannot begin until the ICLB has been approved by BDDS.

8.6 BUILDING COMMUNITY TIES AND ADVOCATING FOR THE INDIVIDUAL

The Ongoing Case Manager serves as an advocate for the individual with service providers and with the community, as well as serving as a partner with the State in providing appropriate and cost-effective services. The Case Manager shall seek to increase the individual's interaction within the community, to seek service delivery for the individual in the most inclusive setting possible, and to assist the individual with locating safe, appropriate housing.

8.7 MONITORING SERVICE DELIVERY AND UTILIZATION

The Ongoing Case Manager closely monitors service delivery and utilization to assure the individual is receiving the needed services and that those services are of high quality. The Case Manager scrutinizes quarterly reports from the service providers to track the individual's progress on goals. In addition, the Case Manager watches utilization to help assure the service provider is delivering services as they were authorized.

8.8 PERIODICALLY UPDATING ELIGIBILITY DETERMINATIONS AND SERVICE PLANS

Periodically as needed, but at least annually, the Ongoing Case Manager will gather the individual's support team to update the PCP process and update the individual's service plan. If the individual's situation or condition changes before the annual plan is due, the updated PCP process and a new plan can be completed at any time needed.

If the individual is on a Medicaid HCBS Waiver Program, the individual's level of care must be updated annually, or more often if the individual's condition significantly changes. The Ongoing Case Manager must consult the appropriate Waiver guidelines for ongoing level of care requirements.

An individual who is not receiving services funded through a Medicaid HCBS Waiver Program does not require an annual level of care determination. In general, this individual would also not require an annual determination that he/she meets the State requirements to receive services for individuals with developmental disabilities. However, if there were significant changes in the individual's condition during the previous year, a redetermination could be needed. The local BDDS district office could provide assistance in deciding if a redetermination is necessary.

8.9 INCIDENT REPORT COMPLETION AND FOLLOW-UP

The Targeted Case Manager shall comply with the BDDS Incident Reporting Policy, including utilizing Incident Reporting Forms and instructions for their submission. (See Attachment D.)

8.10 TRANSITION SERVICES FOR INDIVIDUALS LEAVING AN ICF/MR OR A NURSING FACILITY

The Ongoing Case Manager may coordinate the transition of individuals with developmental disabilities who are leaving an institutional setting (ICF/MR or a nursing facility) for up to six (6) months prior to discharge from the facility. These services cannot duplicate discharge planning done by the facility. The services must follow the procedures established by DDARS.

8.11 COORDINATING CRISIS SERVICES

The Ongoing Case Manager shall assist individuals in crisis by coordinating needed activities, authorizing short term services, and making appropriate referrals for specialized services. A crisis may necessitate a change in service plan or in the ICLB. The Case Manager shall follow the appropriate procedures to assure changes occur quickly and meet the changing needs of the individual.

8.12 MONITORING CONSUMER SATISFACTION AND OUTCOMES

The Ongoing Case Manager shall monitor the satisfaction of the individuals receiving case management services. The Case Manager will also monitor outcomes for the consumer – comparing outcomes planned for in the ISP with actual outcomes.

8.13 RECORDS AND DATABASE UTILIZATION

The Ongoing Case Manager shall maintain careful records that document all case management activities. The Case Manager shall utilize the INsite database to develop needed documents and to facilitate sending those documents.

The Case Manager shall keep records of all services provided and billed a minimum of 3 years from the dates of service provision.

9.0 CASE MANAGEMENT STANDARDS

(NOTE: This section is a restatement of the Case Management Standards section of the pilot Provider and Case Management Standards issued by the Division of Disability, Aging, and Rehabilitative Services.)

The role of case managers is to collaborate with individuals by assessing, facilitating, planning, and advocating for service needs on an individual basis. In order to successfully fulfill this role, case managers must have a working knowledge of the wants and needs of individuals receiving case management services, the array of services available, and the variety of funding resources.

For the purposes of this document, the case manager is defined as an employee of an area agency on aging, a private case management agency, or an independently employed person who has been approved by DDARS to provide case management. For individuals receiving state line-item funding only, BDDS service coordinators serve as case managers.

A. Administrative Standards

1. Case managers shall comply with all federal, state, and local law, and all Family and Social Services Administration policy, rules, regulations, and guidelines.
2. New case managers shall complete case manager orientation as approved by DDARS, prior to being eligible for Medicaid reimbursement. This standard does not apply to BDDS service coordinators.
3. Case managers shall maintain competency by completing 20 hours of DDARS approved training in each calendar year. The training shall include 10 hours of DDARS approved training and 10 hours of related training per calendar year. This is in addition to new case manager orientation. This standard does not apply to BDDS service coordinators.
4. Case managers shall provide each individual/guardian with clear and easy instructions for contacting the case manager or case manager agency. Case managers shall also provide additional information and procedures for individuals who may need assistance or have an emergency that occurs before or after business hours. This information shall be easily accessible and located with other emergency numbers, or visible from the telephone.
5. Case managers shall assure that the individual, the guardian, providers and involved agencies have copies of relevant documentation, including instructions on how to request an appeal.

B. Role of Case Manager in Individual Choice

1. Individuals and/or legal guardians shall choose their service provider(s), including case managers, and shall have the right to change any providers, including case managers.

2. Case managers shall provide to individuals and/or legal guardians a current list of potential providers and case managers, furnished by the State of Indiana, which includes services offered by each provider.
3. Case managers shall provide, at a minimum but not limited to, a state information guide to individuals on how to choose a provider and shall assist the individual in evaluating potential service providers.

C. Case Management Standards for Development of ISP

1. Case managers shall work with the individual, legal guardian (when applicable) and family members throughout the person-centered planning process.
2. Case managers shall ensure that the individual or legal guardian (when applicable) identifies who they wish to serve as the decision-makers and goal setters during the person-centered planning process.
3. Case managers shall assure that person-centered planning is occurring on an ongoing basis and is formally reviewed by the case manager quarterly.
4. Case managers shall assure that the individual's ISP is developed based on the person centered planning process, and that it includes the following components:
    a) Diagnosis;
    b) Individual decision making supports;
    c) Outcomes, including the following components:
        (1) Desired outcomes that are clearly stated and measurable;
        (2) Current status of individual in area of activity for each desired outcome;
        (3) Proposed strategies/activities that provide detail as to how outcome will be attained;
        (4) Clearly stated documentation identifying the responsible party who will be assisting the individual with accomplishing and maintaining the proposed strategies and activities;
        (5) Clearly stated documentation identifying the qualified professional who is responsible for monitoring each service;
        (6) Clearly stated documentation identifying the minimum monitoring visits needed, including type of monitoring visits (face-to-face, in the home, etc.)
        (7) Data collection instructions (i.e. seizure documentation);
        (8) Resources, including how activity is to be supported or funded; and
        (9) Realistic, measurable timeframes for the accomplishment of each desired outcome. Timeframes

should never exceed a year.

d) Types of needed supports. This section of the ISP must include anything and everything that a individual needs in his/her life to maximize personal independence, including but not limited to:

(1) Technology devices such as communication aids, mobility aids, and medical aids that aid in daily living skills. Each individual's ISP will:

(a) document the need for devices, adaptive equipment and/or home modifications deemed necessary for safety and accessibility;

(b) identify which provider is responsible for the provision of the devices or modifications; and

(c) identify funding sources for the equipment/devices.

(2) Supports for strengthening of skills such as the money-management, safety-awareness/alerts, nutrition/healthy eating;

(3) Transportation needs;

(4) Behavioral interventions;

(5) Special diets or dining needs;

(6) Health needs including medication, periodic testing specialty physician visits etc.

(7) Social/emotional supports;

(8) Housing and environmental supports;

(9) Safety of homes; and

(10) Special employment supports.

e) List of current unmet needs of individual that are not addressed in Outcomes section of the ISP, possibly due to limited funding, limited resources available to the individual, or need for individual to attain other skills before goal can be achieved.

f) ISP participants, including full names and signatures.

5. Case managers shall ensure that the support plan is reviewed and updated at least annually, or sooner if there is change in individuals' wants and needs.

6. Case managers shall ensure that the individual and all providers have a current, comprehensive plan of care that meets program fiscal parameters, on which services are based.

7. Case managers shall review and explain to individuals and/or guardians the services that will be provided, and the individuals and/or guardians will sign the plan to show understanding and/or agreement with the plan.

D. Case Management Monitoring Standards

1. Case managers shall monitor and document the quality, timeliness and appropriateness of care, services and products as delivered by providers,

including an assessment of the appropriateness and achievement of goals as stated in each individual's ISP.

2. Case managers shall be responsible for monitoring on an ongoing basis the services and outcomes established for each individual on their caseload as detailed in each individual's ISP.

3. Case managers shall initiate timely follow up of identified problems, whether self identified or referred by others. Critical issues/crisis issues shall be acted on immediately as specified in applicable DDARS, BDDS, or BQIS policies.

4. When concerns with services or outcomes are identified, case managers shall, in a timely manner, take the necessary steps to address the concerns, including, when necessary, involving the person centered planning team. Below are guidelines for how this monitoring should occur:

a) The case manager working within their agency's internal reporting structure first contacts the provider responsible for providing the service and informs them of the concerns. The case manager and provider, using a collaborative approach, establish how the provider will address the concern and in what time frame. This initial contact should be approached by the case manager and provider as a collaborative effort to address the needs of the individual. The results of this contact should be documented in the individual's file. The collaboration should continue as the concerns are addressed, with all professionals involved documenting the steps taken to resolve the issues.

b) The case manager will continue monitoring the services provided to ensure that the provider addresses the concern within the established time frame.

c) If the concerns are not adequately addressed the case manager should determine in his or her professional judgment whether the concerns are serious enough to negatively impact the health and safety or quality of care received by the individual. If the concerns are serious, the next step is to contact the provider in writing, documenting the concerns that have not been addressed and requesting that that providers complete a written response to how they will address the concerns and in what timeframe. Copies of these letters should be forwarded to the appropriate BDDS district office. **Note – this process does not replace the BDDS incident reporting process**.

d) The case manager shall continue to monitor the situation to ensure that the concerns are resolved.

e) If the concerns are still deemed serious and are still not addressed by the provider, the case manager shall forward a letter to the provider documenting the concerns that have not been addressed, that steps that have been taken by the case manager and provider to address the concerns, and the reason the concerns still

exist. Included in the letter should be dates that the case manager has monitored the situation. Copies of these letters should be forwarded to the Director of BQIS, who will review each situation and develop a plan of correction or plan of action to address the concerns.

5. A maximum response time between implementation of the support plan and the first monitoring contact shall be no more than 30 calendar days or sooner if specified in the ISP.
6. Case managers shall have face-to-face contact with each individual as determined in the ISP, with a minimum of at least one visit every ninety (90) days to assess the quality and effectiveness of the support plan. A minimum of two of these face-to-face contacts per year shall be in the home setting. It is recommended that at least one visit be unannounced.
7. Case managers shall have access to providers' quality procedures for assessment purposes.

E. Case Management Documentation/File Maintenance Standards

1. Case managers shall document, in the chronological narrative, each contact with individuals and each contact with providers.
2. Case managers shall keep all files in a standardized format and sequence.
3. Case managers shall maintain privacy and confidentiality of all individual records. No information shall be released/shared with others without the individual/guardian's informed consent.
4. Case managers shall provide to the State, upon request, ready access to all case manager documentation, either electronic or hard copy.
5. Case manager documentation shall demonstrate that the safety and welfare of the individual is being monitored on a regular basis.
6. Case managers shall comply with all automation standards and requirements as prescribed by applicable agency for documentation and processing of case management activities.
7. All documentation of follow-up and resolutions of problems shall be completed in the individual record.
8. When individuals change case managers, the existing case manager shall forward all individual records/files to the new case manager within seven days of transfer.

10.0 PROVIDER CERTIFICATION AND MEDICAID ENROLLMENT

The Intake Case Management component of Targeted Case Management services for individuals with developmental disabilities shall be provided by:

1. The district offices of the Bureau of Developmental Disabilities Services; or
2. The local Area Agencies on Aging.

The Ongoing Case Management component of Targeted Case Management services for individuals with developmental disabilities shall be provided by any entity who wishes to become a Medicaid provider and meets the State's requirements.

Entities and their employees that have been approved by the Bureau of Developmental Disabilities Services to provide services for persons with developmental disabilities may be certified to provide Targeted Case Management. These entities/individuals may not, however, provide Targeted Case Management to the individuals on the DD Waiver or the Autism Waiver or to individuals served by BDDS Residential Services money in 24-hour settings. In addition, an individual/employee providing other DD services to an individual, may not provider case management to that individual.

10.1 INDIANA BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES

To be eligible for Medicaid reimbursement of Intake Targeted Case Management activities, the BDDS shall complete both a Medicaid/Children's Health Insurance Program Provider Agreement and an Addendum to that Agreement for Targeted Case Management for Individuals with Developmental Disabilities and submit them to the following address:

Indiana Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services
Bureau of Fiscal Services
Attn: Targeted Case Management Provider Enrollment
402 West Washington Street, W-451
P.O. Box 7083, MS21
Indianapolis, IN 46207-7083

Note: the Addendum (see Attachment E) must be submitted with the most current version of the Medicaid/Children's Health Insurance Program Provider Agreement, available from the www.indianamedicaid.com website. A sample Provider Agreement is included as Attachment F to this manual for example purposes only.

As appropriate, the Bureau of Fiscal Services shall send written certification to the BDDS as a provider of Intake Targeted Case Management services.

The Bureau of Fiscal Services shall send its certification, the BDDS Medicaid Provider Agreement, and Addendum to EDS Provider Enrollment for enrollment as a provider and issuance of a Medicaid Provider Number.

Certification of BDDS staff to perform Intake Targeted Case Management and complete ICF/MR level of care determinations shall be completed by BDDS administrative staff.

To perform Intake Targeted Case Management, the certification must be in writing and assure that the person meets the following criteria:

1. Is employed in an Indiana State Personnel Merit System Professional, Administrative and Technological III (PAT III) position. The requirements for PAT III are:
    a) Four years of full-time paid employment plus two years of full-time paid professional experience in program development, coordination, or implementation;
    b) Accredited college training may substitute for the required experience, with a maximum substitution of three years;
    c) Accredited graduate school training may substitute for the required experience with a maximum substitution of two years.

    And
2. Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities.

To complete ICF/MR level of care determinations, the certification must be in writing and assure that the person meets the following additional criteria:

3. Meets the federal standard for Qualified Mental Retardation Professional (QMRP) at 42CFR 483.430 (a) and (b) which provides that an individual:
    a) Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and
    b) Is one of the following: a doctor of medicine or osteopathy; a registered nurse; an occupational therapist; an occupational therapy assistant; a physical therapist; a physical therapy assistant; a psychologist; a social worker; a speech-language pathologist or audiologist; a recreational therapist; a dietician; or

    Has a Bachelor's degree in a human services field.

10.2 AREA AGENCIES ON AGING

To be eligible for Medicaid reimbursement of Intake and/or Ongoing Targeted Case Management activities, the AAA shall complete both a Medicaid/Children's Health Insurance Program Provider Agreement and an Addendum to that Agreement for Targeted Case Management for Individuals with Developmental Disabilities and submit them to the following address:

Indiana Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services
Bureau of Fiscal Services
Attn: Targeted Case Management Provider Enrollment
402 West Washington Street, W-451
P.O. Box 7083, MS21
Indianapolis, IN 46207-7083

Note: the Addendum (see Attachment E) must be submitted with the most current version of the Medicaid/Children's Health Insurance Program Provider Agreement, available from the www.indianamedicaid.com website. A sample Provider Agreement is included as Attachment F to this manual for example purposes only.

As appropriate, the Bureau of Fiscal Services shall send written certification to the AAA as a provider of Intake and/or Ongoing Targeted Case Management services.

The Bureau of Fiscal Services shall send its certification, the AAA's Medicaid Provider Agreement, and Addendum to EDS Provider Enrollment for enrollment as a provider and issuance of a Medicaid Provider Number.

Certification of AAA staff to perform Intake and/or Ongoing Targeted Case Management and complete ICF/MR level of care determinations shall be completed by AAA administrative staff.

To perform Intake and/or Ongoing Targeted Case Management, the certification must be in writing and assure that the person meets the following criteria:

1. Meets the federal standard for Qualified Mental Retardation Professional (QMRP) at 42CFR 483.430 (a) and (b) which provides that an individual:
    a) Has at least one year of experience working directly with person with mental retardation or other developmental disabilities; and

    b) Is one of the following: a doctor of medicine or osteopathy; a registered nurse; an occupational therapist; an occupational therapy assistant; a physical therapist; a physical therapy assistant; a psychologist; a social worker; a speech-language pathologist or audiologist; a recreational therapist; a dietician; or
    Has a Bachelor's degree in a human services field; OR

2. Was certified to provide Case Management services under a 1915 (c) Medicaid Home and Community-Based Waiver for persons with developmental disabilities on September 30, 2001.

In addition, Targeted Case Management entities may employ Targeted Case Manager "Designees". Designees must meet the following requirements:

1. At least a 4-year college degree with no direct-care experience; or
2. A high school diploma, or equivalent and at least 5 years experience working with people with mental retardation or other developmental disabilities.

Accumulated college experience can count toward required experience in #2. (For example, a persons with an Associate's degree and 3 years experience could qualify as a Targeted Case Manager Designee. Additionally, if an individual has the appropriate education, serving as a Designee for a year will provide the appropriate direct-care experience to become a QMRP.

Designees must be supervised by a QMRP at a level of no more than 5 Designees for each QMRP. Designees are allowed to participate in the day-to-day case management of individuals, however, a supervisor (QMRP) must make Level of Care determinations, sign off on Plans of Care and take an active role in monitoring the case.

To complete ICF/MR level of care determinations, the certification must be in writing and assure that the person meets the federal standard for QMRP, as stated above.

10.3 ENTITIES CERTIFIED AND ENROLLED AS MEDICAID PROVIDERS OF CASE MANAGEMENT SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES ON SEPEMBER 30, 2001

To be eligible for Medicaid reimbursement of Ongoing Targeted Case Management activities, an entity (individual or corporation) certified and enrolled as a Medicaid provider of Case Management services under 1915 (c) Waivers for persons with developmental disabilities on September 30, 2001 shall complete both a Medicaid/Children's Health Insurance Program Provider Agreement and an Addendum to that Agreement for Targeted Case Management for Individuals with Developmental Disabilities and submit them to the following address:

Indiana Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services
Bureau of Fiscal Services
Attn: Targeted Case Management Provider Enrollment
402 West Washington Street, W-451
P.O. Box 7083, MS21
Indianapolis, IN 46207-7083

Note: the Addendum (see Attachment E) must be submitted with the most current version of the Medicaid/Children's Health Insurance Program Provider Agreement, available

from the www.indianamedicaid.com website. A sample Provider Agreement is included as Attachment F to this manual for example purposes only.

As appropriate, the Bureau of Fiscal Services shall send written certification to the entity as a provider of Ongoing Targeted Case Management services.

The Bureau of Fiscal Services shall send its certification, the entity's Medicaid Provider Agreement, and Addendum to EDS Provider Enrollment for enrollment as a provider and issuance of a Medicaid Provider Number.

Certification of staff to perform Ongoing Targeted Case Management and complete ICF/MR level of care determinations shall be completed by the entity's administrative staff. When the entity consists of a single individual, certification to perform Ongoing Targeted Case Management and complete level of care determinations shall be completed by the Bureau of Fiscal Services.

To perform Ongoing Targeted Case Management, the certification must be in writing and assure that the person meets the following criteria:

1. Meets the federal standard for Qualified Mental Retardation Professional (QMRP) at 42CFR 483.430 (a) and (b) which provides that an individual:
    a) Has at least one year of experience working directly with person with mental retardation or other developmental disabilities; and
    b) Is one of the following: a doctor of medicine or osteopathy; a registered nurse; an occupational therapist; an occupational therapy assistant; a physical therapist; a physical therapy assistant; a psychologist; a social worker; a speech-language pathologist or audiologist; a recreational therapist; a dietician; or
    Has a Bachelor's degree in a human services field;

Or

2. Was certified to provide Case Management services under a 1915 (c) Medicaid Home and Community-Based Waiver for persons with developmental disabilities on September 30, 2001.

In addition, Targeted Case Management entities may employ Targeted Case Management Designees. See Section 10.2 for requirements.

To complete ICF/MR level of care determinations, the certification must be in writing and assure that the person meets the federal standard for QMRP, as stated above.

10.4 NEW PROVIDERS OF ONGOING TARGETED CASE MANAGEMENT

Entities wishing to become providers of the Ongoing component of Targeted Case Management services for individuals with developmental disabilities should contact the following:

Indiana Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services

Bureau of Fiscal Services
Attn: Targeted Case Management Provider Enrollment
402 West Washington Street, W-451
P.O. Box 7083, MS21
Indianapolis, IN 46207-7083
(317) 233-9675

The following information shall be submitted in writing to gain approval as a provider of Ongoing Targeted Case Management:

1. If certified to provide other BDDS or waiver services for persons with developmental disabilities, the entity must assure that the specific individual(s)/employee(s) who are providing other DD service(s) to an individual will not provide Targeted Case Management to that individual. Additionally assurances must be made that the entity will not provide Targeted Case Management to individuals on the DD or Autism Waiver; nor to individuals served by BDDS Residential Services money in 24-hour settings (not including Residential Living Allowance funding).
2. Assurance of the capacity to provide all elements of Ongoing Targeted Case Management services.
3. Assurance of experience with the needs of individuals with developmental disabilities.
4. Assurance of experience in coordinating and linking such community resources as required by individuals with developmental disabilities.
5. Assurance of a financial management capacity and system that provides documentation of services and costs,
6. Assurance of capacity to deliver services without interruption.
7. Assurance of a capacity to document and maintain individual case records in accordance with State and Federal requirements.
8. Assurance that the entity will employ case managers who meet the federal standard for Qualified Mental Retardation Professional (QMRP) at 42CFR 483.430 (a) (b) which provides that an individual:
    a) Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and
    b) Is one of the following: a doctor of medicine or osteopathy; a registered nurse; an occupational therapist; an occupational therapy assistant; a physical therapist; a physical therapy assistant; a psychologist; a social worker; a speech-language pathologist or audiologist; a recreational therapist; a dietician; or
    Has a Bachelor's degree in a human services field.
9. Written documentation from the State Police or other law enforcement agency verifying that the principle parties involved in the management and administration of the entity have not been convicted of a felony or an act involving:
    a) Neglect or abuse of a dependent person;

b) Abuse or fraud in any setting;
c) Mismanagement of funds;
d) Violent crime; or
e) Other actions which raise concerns regarding the entity's ability to provide services safely.

10. If incorporated, copies of letters of incorporation signed by the Indiana Secretary of State's office.

As appropriate, the Bureau of Fiscal Services shall send to the entity, written certification as a provider of Ongoing Targeted Case Management services and certification to complete ICF/MR level of care determinations. The provider will also be sent the most current version of the Medicaid/Children's Health Insurance Program Provider Agreement and an Addendum to that Agreement for Targeted Case Management for Individuals with Developmental Disabilities.

Note: the Addendum (see Attachment E) must be submitted with the most current version of the Medicaid/Children's Health Insurance Program Provider Agreement, available from the www.indianamedicaid.com website. A sample Provider Agreement is included as Attachment F to this manual for example purposes only.

The entity shall return both the completed Addendum and Medicaid Provider Agreement to the Bureau of Fiscal Services.

The Bureau of Fiscal Services shall send its certification, the entity's Medicaid Provider Agreement, and Addendum to EDS Provider Enrollment for enrollment as a provider and issuance of a Medicaid Provider Number.

Certification of additional staff to perform Ongoing Targeted Case Management and complete ICF/MR level of care determinations shall be completed by the entity's administrative staff. The certification must be in writing and assure that the person meets the QMRP requirements, as stated above.

11.0 MEDICAID PROVIDER REIMBURSEMENT

Targeted Case Management for Individuals with Developmental Disabilities shall be billed on the HCFA 1500 form. Completed forms should be sent directly to the Medicaid fiscal agent to receive reimbursement.

Electronic billing is also possible. Entities interested in billing electronically for these services should contact the Medicaid fiscal agent to obtain the appropriate software and billing manual.

Claims will be processed by the Medicaid fiscal agent only for individuals who are actually enrolled in Medicaid and eligible on the dates of the Targeted Case Management services being billed by the provider of services.

The Medicaid effective date may be up to three months retroactive to the date of Medicaid application, if the individual is determined eligible. As a result, an individual whose Medicaid eligibility is pending may receive Targeted Case Management services and the provider may submit claims after the individual's eligibility is approved.